

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **34682**

FILED OCT 27 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 943

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 2145 Washington	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print) HANNAH	a. (First)	b. (Middle)	c. (Last) HENDERSON	4. DATE OF DEATH (Month) (Day) (Year) Oct. 18 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 19 March 1878	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and State or Foreign County) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Lowery	13b. MOTHER'S MAIDEN NAME Martha	14. NAME OF HUSBAND OR WIFE B.F. Henderson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME B.F. Henderson	ADDRESS Springfield, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 hour
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion		
	ANTECEDENT CAUSES DUE TO (b) Arterio-Sclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 6-21, 1952 to 10-18, 1952 that I last saw the deceased alive on 10-17, 1952, and that death occurred at 12:05A m., from the causes and on the date stated above.

23a. SIGNATURE Max Velt (Degree or title) M.D.	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 10-18-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 19, 1952	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield Mo.
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DATE REC'D BY LOCAL REG. 10-20-52	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE W. Klingner & Co.	ADDRESS Springfield, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

May Rhodes

Licensed Embalmer No. 4071

P. O. Address Spring Hill

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.